

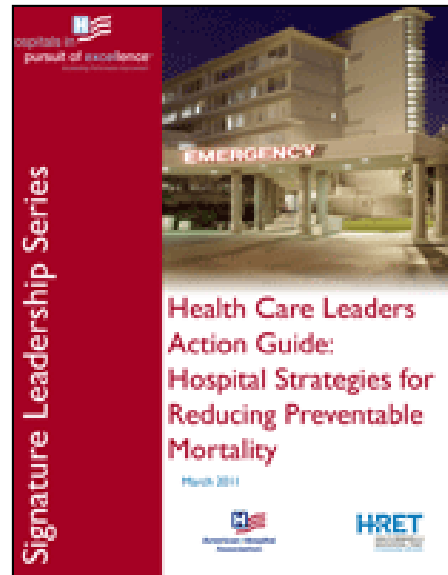
Health Care Leader Action Guide: Hospital Strategies for Reducing Preventable Mortality

March 2011



TRANSFORMING HEALTH CARE THROUGH RESEARCH AND EDUCATION





Health Care Leaders Action Guide: Hospital Strategies for Reducing Preventable Mortality. Health Research & Educational Trust, Chicago, IL. February 2011. Accessed at www.hpoe.org.

2011-13 AHA Strategic Plan

- Strategic performance commitments that identify specific targets for hospital efforts to improve patient care:
 - reduce central line-associated bloodstream infections (CLABSIs)
 - eliminate preventable readmissions
 - *eliminate preventable mortality*

Why Is Focusing On Preventable Mortality Important?

- Much has been written about the numbers of patients that die unnecessarily in hospitals.
 - *To Err is Human: Building a Safer Health System* (IOM, 1999) - between 48,000 and 98,000 deaths from medical errors occur each year in U.S. hospitals
- While most hospital deaths are not due to failures in care delivery, many deaths are preventable and this presents an important opportunity for hospital leaders to address.

Why Is Focusing On Preventable Mortality Important? (contd.)

- By collectively pursuing improvement strategies in a visible and measurable way, hospitals will be joining forces to advance a health care system that delivers the right care, to the right patient, in the right place.
- Hospital mortality also an issue that easily resonates with the public
- Demonstrable improvement in this area will go a long way towards maintaining and strengthening public confidence in our nation's hospitals.

Where Should Hospital and Health System Leaders Begin?

- Start by looking at your data
 - Understand how your hospital compares to the national average mortality rate for each condition.
 - Explore other proxy measures to monitor mortality on a more timely basis.
 - Be aware that Hospital Compare includes mortality rates for Medicare patients only and other proxy measures of mortality may include all patients.
- Set a specific, visible, and measurable goal with timelines for reducing mortality.
 - Make this a strategic priority for your organization and be persistent about communicating the goal and your progress organization-wide.

Where Should Hospital and Health System Leaders Begin? (contd.)

- Decide where to focus your hospital's improvement efforts.
 - Begin with the obvious, e.g., *Hospital Compare* care process measures for heart attack, heart failure, and pneumonia? Are there opportunities for improvement?
- Consider cross-cutting concerns.
 - Numerous examples of interventions involving healthcare-associated infections, delays in responding to patients with deteriorating conditions, poor communication, surgical complications, and medication and medical errors

Where Should Hospital and Health System Leaders Begin? (contd.)

- Align your quality improvement activities and create a visual map.
 - Can help to give leaders and staff a sense of priority and awareness of how many of the activities they are working on fit into the organization's strategic goals.
- Establish an organized process for reviewing mortality.
 - Structured process for monthly mortality case review, including structured review forms, interdisciplinary committees, and identification of systemic opportunities for improvement.
 - Nursing departments also reviewing mortality as a way to identify system issues in care and improve nursing practice.

Where Should Hospital and Health System Leaders Begin? (contd.)

- Integrate these improvement efforts into your hospital's quality improvement program and develop an action plan for implementing these strategies.
 - Establish improvement teams with caregivers affected by the improvement process and provide visible executive leadership support
- Be accountable.
 - Put this on the agenda of board and senior leadership meetings and actively review progress.

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